

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969275	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/25/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SEASIDE AT FORT MYERS

**15800 BEACHWALK BLVD
FORT MYERS, FL 33908**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A follow-up survey by desk review was conducted on 6/20/25 through 6/25/25 for Seaside at Fort Myers, an assisted living facility in Fort Myers, Florida. This was a follow-up to the relicensure, extended congregate care, limited nursing services, emergency power plan monitoring, health facility reporting system, and visitation form survey completed on 4/30/25. Based on the facility's plan of correction, and supporting documentation, the deficiencies were corrected as of 6/13/25 and no new deficiencies were identified at the time of the survey.	{A 000}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE